| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105125 | A. Building<br>B. Wing | 06/06/2025 |

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| Terraces of Lake Worth Care Center and Rehab | 1711 6th Avenue South<br>Lake Worth, FL 33460 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167<br><br>Based on policy review, observation, interview, and record review, the facility failed to initiate and act on grievances regarding dialysis chairs, affecting 2 of 2 sampled residents, Residents #31 and #344.<br><br>The findings included:<br><br>Review of the policy titled grievances/complaints, filling, dated April 2017, indicated the following: residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the state ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the residents and/or representatives. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. All grievances, complaints, or recommendations stemming from residents or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator within ten working days of receiving the grievance and/or complaint.<br><br>1. Review of the clinical record revealed Resident #31 was admitted to the facility on the following dates: 03/22/25, 04/18/25, and 05/10/25, with diagnoses including medically complex conditions and End-Stage Renal Disease. Review of the 5-day modified minimum data set assessment, reference date 04/23/25, recorded a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #31 was cognitively intact. This assessment recorded mood symptoms but no behavior symptoms. This assessment revealed Resident #31 depended on assistance for mobility, such as rolling left and right, sitting to lying, lying to sitting on the side of the bed, sitting to stand, and chair/bed-to-chair transfer.<br><br>Review of progress notes dated 04/15/25 recorded Resident #31 had an open blister on the left buttock. The skin of the sacrum was already impaired with excoriations and had worsened. A current treatment with Medihoney and calcium alginate was in place.<br><br>Review of the physician ordered included the following from 05/10/25:<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - Cleanse the sacrum with normal saline. Apply Medihoney with calcium alginate and cover with a dry dressing.<br><br>- Turn and reposition every 2 hours and as needed, per protocol. Encourage the resident to turn and reposition every 2 hours during each shift.<br><br>- A Roho cushion for the wheelchair, with functionality checks required every shift.<br><br>- A consultation for wound care was suggested.<br><br>- Communicate with the dialysis center regarding labs and the plan of care.<br><br>Review of the care plan dated 05/07/25 documented Resident #31 had skin impairment as follows: Pressure ulcer to Sacrum Stage 3. She received in-house dialysis on Mondays, Wednesdays, and Fridays, chair time at 9 AM.<br><br>On 06/03/25 at 10:34 AM, during an interview with Resident #31, she stated, She had acquired wounds; she stayed in the dialysis chair for too long, for about 4 hours, and the chair was hard. She had complained to the dialysis center and the facility about the chair; she needed a cushion.<br><br>A subsequent interview was held with Resident #31 on 06/05/25 at 12:08 PM. She voiced yesterday (on 06/04/25) that she went to dialysis. There was no cushion on the chair, so it felt uncomfortable, and she was in pain. Someone at the dialysis center placed a pillow on the chair, and it felt better.<br><br>On 06/06/25 at 7:18 AM, an interviewwas conducted with the wound care nurse (WCN). She voiced that Resident #31 was admitted with a deep tissue injury of the sacrum. When inquired about the dialysis chair, she said she had heard somebody saying the dialysis residents were complaining about the chair not being comfortable; was unsure which residents had complained, and was uncertain if it was Resident #31. During the interview, the dialysis chair was observed positioned across the resident room in the hallway>. It was a recliner-type chair with no cushion.<br><br>At 7:25 AM, the WCN spoke with Resident #31 and asked the resident about the dialysis chair. Resident #31 informed her it was uncomfortable; hard to sit on; and she had been complaining about the chair.<br><br>At 7:27 AM, while further discussing the dialysis chair, the Rehab Director joined the conversation and stated, They had tried putting the roho cushion on the dialysis chair, but the resident didn't like it in there and the roho has made it more uncomfortable for her. The Rehab Director stated, We can put a cushion in there, we can try it, we have plenty of cushions if she has issues, we can remove it.<br><br>At 7:29 AM, the Rehab Director placed a cushion on the chair, and stated the resident had brought her own cushion in. We discussed it in the Interdisciplinary meeting.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 7:32 AM, another interview was conducted with Resident #31 who stated, She brought a cushion for the wheelchair, only for the wheelchair, not the dialysis chair. During this conversation with Resident #31, her roommate (Resident #344) interjected and stated, Miss, the dialysis chair is uncomfortable; it hurts; I am a dialysis patient as well, today I got to go to dialysis, and I am worried, I am freaking out because I have to sit in that chair.<br><br>On 06/06/25 at 9:38 AM, during an encounter with the Rehab Director, she said, I think I may have misled you earlier when we spoke; and there was not a formal trial conducted by therapy regarding the dialysis chair. She advised the surveyor to go to her office for an additional interview and explained that yesterday, during the interdisciplinary meeting, somebody mentioned the residents said the dialysis chair was uncomfortable, and that's when it was brought to her attention. She further explained that she had just found out Resident #31 said she had tried the roho cushion in the dialysis chair and it was uncomfortable, so she had taken it upon herself to buy another cushion. The Rehab Director stated if we're going to have residents with sacral wounds going to dialysis that are in those types of chairs that don't seem to provide cushion for the wounds, the we need a roho cushion for the chair or a wound-appropriate chair with cushions. If somebody had brought the concern sooner to her attention, she would have jumped on it right away and addressed it.<br><br>On 06/06/25 at 10:26 AM, an interview was conducted with the Social Worker and the Assistant Director of Nursing (ADON). Thhe ADON revealed that since March 2025, the facility has started to provide in-house dialysis. This week, Resident #31 complained about the uncomfortable dialysis chair, which was discussed with the interdisciplinary team on Monday. The ADON stated she ahd mentioned it to the dialysis staff, and they said that's what they had. When asked, if the team or designated member wrote up a grievance and how they addressed Resident #31's concern when they found out about it, the ADON and the social worker acknowledged that a grievance should have been started to better address this concern, but they couldn't convey how Resident #31's concern was addressed.<br><br>On 06/06/25 at 10:36 AM, an interview was conducted with Staff E, the Director of the Dialysis Center, who voiced that last week Friday (05/30/25), Resident #31 voiced the dialysis chair was uncomfortable, was too hard, and after speaking to her, she adjusted her chair but did not put a cushion. On Wednesday (06/04/25), Resident #31 complained about the chair again sand he provided a pillow. She stated, today she urged her to put a cushion that she finds most comfortable to sit on, in the dialysis chair before coming to dialysis. She stated the resident received dialysis for 3 hours and 45 minutes. She stated that when Resident #31 initially complained of pain, she thought it was because she woke up too early for dialysis, so she changed her dialysis chair time to noon, and then she found out the pain was related to the chair. Staff E stated, We need more support / cushion for the chair.<br><br>2. Record review revealed Resident #344 was admitted to the facility on [DATE]. Review of the baseline care plan dated 05/30/25 revealed Resident #344 had the potential for skin impairment / pressure ulcers related to impaired mobility and a diagnosis of Diabetes Mellitus. The intervention included Pressure-reducing cushions for the wheelchair.<br><br>Review of the admission progress notes dated 05/29/25, at 3:41 PM, doicumented Resident #344 was admitted to the facility from the hospital, as being alert and oriented times 3. The BIMS score was documented as 15 indicating Resident #344 was cognitively intact.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/03/25 at 10:40 AM, an interview was held with Resident #344, who stated, Her only concern was regarding the dialysis chair. It is very uncomfortable, very hard. She sat in the chair for three and a half hours. They need to have a better chair. It's so uncomfortable to sit in the chair. It hurts her back. She receives in-house dialysis. She spoke to the dialysis center about the chair.<br><br>On 06/06/25 at 9:32 AM, reviews of the grievance log lacked documented concerns relating to Resident #31 and #344. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews and record reviews, the facility failed to accurately document the status of upper and lower extremity impairment for 1 of 19 sampled residents, Resident #52.<br><br>The findings included:<br><br>Record review revealed Resident # 52 was admitted on [DATE] with diagnoses that included Quadriplegia, Paraplegia, Neuromuscular Dysfunction of Bladder, Gastroesophageal Reflux Disease without Esophagitis, and Anemia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating Resident #52 had intact cognitive function.<br><br>Section GG-A of the upper extremity including shoulder, elbow, wrist and hand revealed 0 or no impairment. Further review of Section GG-B of the lower extremity including the hip, ankle, knee and foot revealed 0 or no impairment.<br><br>Section GG-C for toileting hygiene, including the ability to maintain perineal hygiene, adjusting clothes before and after voiding or having a bowel movement revealed a 01 or resident was dependent.<br><br>Section GG-E for shower and bathing self, including washing, rinsing, and drying self, but does not include transferring in and out of the shower, revealed a 02 or the resident needed substantial maximal assistance.<br><br>Record review of a Nurse Practitioner's progress notes dated 05/16/25 revealed Resident #52 had a past medical history of Quadriplegia (a paralysis condition that affects the ability to voluntarily move the upper and the lower body), requiring full care, bilateral hydronephroses, chronic indwelling urinary catheter, urinary catheter malfunction, urinary tract infection and hematuria.<br><br>Review of the nursing care plan dated 06/03/25 revealed Resident #52 has a potential for pain and or alteration in comfort related to impaired mobility due to the diagnoses of Quadriplegia, Paraplegia (a condition characterized by the loss of sensation and movement in the lower half of the body) and Neuropathy.<br><br>An interview was conducted with Resident #52 on 06/03/25 at 10:30 AM, who stated he was admitted back to the facility in February 2025 with loss of sensation and feelings from the chest down to his feet. When asked if he can move his fingers, and arms, he stated he had fractured his thumb, and his fingers are not able to have full sensation, but he is able to point a finger to access his telephone with much difficulty. He added that when he was admitted , he was not able to move most of his fingers.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with Resident #52's spouse on 06/03/25 at 3:00 PM, who stated Resident #52 had no sensation from the chest down. He has some little functional abilities on his right hand, and is able to point one finger, but has little grasping abilities for both hands. She added he is improving little by little in using one finger or two fingers to touch his electronic gadgets.<br><br>An interview was conducted with the Regional Minimum Data Set (MDS) consultant on 06/06/25 at 2:13 PM who when asked how the MDS Coordinator staff would assess the functional abilities of the upper and lower extremities for MDS assessment documentation, she responded, if the resident has any capacity to move a joint, then there is no impairment. When she was asked how she defines paraplegia and hemiplegia, and the ability to move both the upper and the lower extremities, would she document no impairment in MDS assessment, and she did not respond, but added she would try to assess the resident again. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on observations, interviews and record review, the facility failed to accurately administer medication for 2 of 6 observations of medication pass, Resident #43 and Resident #86; and failed to follow blood pressure parameters for 1 of 5 sampled resident reviewed for unnecessary medications, Resident #9.<br><br>The findings included:<br><br>Review of the facility's policy, titled, Administering Medications, with a revised date of April 2019, included in part the following: Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>1. Record review for Resident #43 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 05/30/25 with diagnoses that included in part the following: Protein-Calorie Malnutrition, Dementia, and Sepsis. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment.<br><br>Review of the Physician's Orders for Resident #43 revealed an order dated 05/30/25 for Florastor Oral Capsule 250 MG (Saccharomyces boulardii, type of Probiotic) give 1 capsule by mouth one time a day for digestive health for 10 Days and was discontinued on 06/05/25. In summary, there was no current order for Lactobacillus 250mg.<br><br>During medication (med) pass observation conducted on 06/05/25 at 8:40 AM with Staff A, Licensed Practical Nurse (LPN), for Resident #43, administered meds to include Lactobacillus 250mg given orally.<br><br>An interview was conducted on 06/05/25 at 8:45 AM with Staff A who stated she has worked at the facility for 2 years. When asked about the Lactobacillus 250mg administered to Resident #43 when in fact the resident had an order for Florastor Oral Capsule 250 MG (Saccharomyces boulardii), she said it was the facility uses, it is the same thing.<br><br>An interview was conducted on 06/05/25 at 8:50 AM with the Assistant Director of Nursing (ADON) who was asked about Resident #43 and receiving Lactobacillus 250mg instead of the prescribed Florastor Oral Capsule 250 MG (Saccharomyces boulardii), the ADON stated it is the same thing. Later the ADON returned to this surveyor and clarified that the 2 medications were similar, but not the same.<br><br>50370<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review revealed Resident #86 was admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation, Malignant Neoplasm of unspecified part of the bronchus or lungs, Major Depressive Disorder and Essential Primary Hypertension.<br><br>Review of recent Minimum Data Set (MDS) assessment dated [DATE] under Section C for the BIMS revealed a score of 14 indicating Resident # 86 had intact cognitive function.<br><br>Review of physician orders dated 04/23/25 revealed an order for: Ipratropium-Albuterol Inhalation solution, 0. 5, 1 vial, 2.5, 3 mg (milligram)/ 3 ml (milliliter), inhale orally every 8 hours for COPD, until 05/26/25.<br><br>Review of May 2025 Medication Administration Record (MAR) revealed Albuterol inhalation solution was given every 8 hours from 05/01/25 until 05/26/25. The MAR also revealed that Staff A and Staff F, both LPNs, had administered the Albuterol inhalation several times during the month of May in 2025.<br><br>During observation on 06/03/25 at 2:10 PM, the resident was not in the room, but an oxygen concentrator was on the floor, and a nebulizing mask next to a nebulizing machine was on top of the resident's bedside table. The oxygen tubing for the nebulizing mask was dated. There was an extra oxygen tank on an oxygen cart observed at the bottom part of Resident #86' bed.<br><br>An interview was conducted with the resident on 06/04/25 at 11:49 AM, who stated the Albuterol treatment she usually gets during day, afternoon and night shifts suddenly stopped on Friday, 05/30/25. She asked nurses but no one could tell her why the Albuterol treatment was stopped. She added that she told one staff, and the staff told her that a physician order is needed for her to receive additional Albuterol treatments. She stated she cannot remember the name of the staff.<br><br>Another interview with the resident was conducted on 06/05 25 at 11:49 AM, who when asked if she ever refused medications, she responded, no. She added that she did not receive her Albuterol treatment since last Friday. She stated the nurses would not explain why she did not receive it yesterday and today. She added the Albuterol treatment helped her breathe easier. She added she is having a respiratory problem as soon as she wakes up. When she was receiving the Albuterol treatment, she was having an easier time waking up and getting to her usual daily activities. Resident # 86 was later heard with a very productive cough.<br><br>An interview was conducted with Staff A on 06/04/25 at 11:20 AM, who stated she would check if the resident had an order for Albuterol treatment. She added that she does not know if the resident has Albuterol treatment.<br><br>An interview was conducted with Staff J, LPN, on 06/05/25 at 11:48 AM, who asked about the Albuterol treatment for the resident, and responded, she would check the order. She added that she does not know if the resident is on any Albuterol inhalation treatment.<br><br>Review of physician orders dated 06/05/25 revealed an order for: Ipratropium-Albuterol inhalation solution, 0. 5, 1 vial, 2.5, 3 mg (milligram)/ 3 ml (milliliter), orally every 6 hours as needed for shortness of breath and wheezing.<br><br>39167<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Record review revealed Resident #9 was admitted to the facility on [DATE], with a diagnosis of Hypertension. The admission MDS assessment, reference date 03/31/25, recorded a BIMS score of 15, indicating the resident was cognitively intact.<br><br>Review of the physician orders dated 03/25/25, prescribed Hydralazine oral tablets at a dosage of 50 mg to be taken by mouth twice a day for Hypertension. The order specified holding the medication if the systolic blood pressure was less than 110 or the heart rate was less than 60.<br><br>The baseline care plan dated 03/26/25 noted that Resident #31 had the potential for complications related to altered cardiac function due to diagnoses of hypertension and atrial fibrillation. The interventions included administering medications as ordered and observing for effectiveness and side effects.<br><br>Review of the medication and treatment administration records (MARs and TARs) for May 2025 indicated that Hydralazine 50 mg was administered on May 2 at 5 PM, with a blood pressure reading of 100/69, and again on May 8, with a blood pressure reading 99/62.<br><br>On 06/05/25 at 11:14 AM, the regional nurse consultant confirmed that Hydralazine had been administered despite the low systolic blood pressure readings on May 2 and May 8 at 5 PM. When asked about the policy regarding administering blood pressure medication parameters, she stated, There was no policy; it goes under the physician's orders. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893<br><br>Based on observations, interviews, record reviews and facility policy review, the facility failed to ensure a safe smoking environment by not providing safety devices and supervision per the residents' care plans and assessments for 6 of 10 sampled residents that smoke, Residents #6, #30, #36, #77, #86 and #399. The facility failed to assess residents for safe smoking at least quarterly and as needed for 4 of 10 sampled residents, Residents #6, #36, #77, and #86.<br><br>The findings included:<br><br>Review of the facility's Smoking Policy, with a revision date of 04/26/25, documented:<br><br>Procedures:<br><br>Residents will be assessed upon admission, quarterly and on an as needed basis as to their need for required assistance or special safety devices.<br><br>All residents determined to need supervision according to safe smoking evaluation:<br><br>1. Will be observed when smoking by a staff member during designated supervised times.<br><br>2. All smoking materials of residents who require supervision will be kept at the Division 1 Nursing Office.<br><br>3. All friends and family members will be instructed not to give resident any smoking materials.<br><br>4. All smoking materials will be left in the 1st floor Nursing Office.<br><br>1. Record review revealed Resident #6 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual / Medicare 5-Day Minimum Data Set (MDS) assessment, with a reference date of 05/12/25, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident was moderately cognitively impaired. The assessment documented Resident #6 was dependent upon staff for bed mobility and transfers and ambulated with assistance via a manual wheelchair. Resident #6's diagnoses at the time of the assessment included: Stroke, Hemiplegia following cerebral infarction, Cancer, Anemia, Coronary Artery Disease (CAD), Arthritis, Hemiplegia, Paraplegia, Seizure disorder, Psychotic disorder, Abnormalities of gait and mobility, Dysphagia, Osteoarthritis, and idiopathic peripheral autonomic neuropathy.<br><br>Review of Resident #6's care plan for mood documented:<br><br>Resident has an alteration OR potential for alteration in mood as evidenced by complaints of or displays the following: History of: Anxiety, Psychosis - Verbally Abusive to staff - History of smoking in lobby, psychically threatening staff, taunting staff - Delusional - he says he was a former Navy Seal, thinks he fought in Vietnam war (per family, he was not).<br><br>(continued on next page) |

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|---|---|---|---|
| | 105125 | A. Building<br>B. Wing | 06/06/2025 |

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| Terraces of Lake Worth Care Center and Rehab | 1711 6th Avenue South<br>Lake Worth, FL 33460 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #6's care plan for smoking documented:<br><br>Resident desires to smoke. Resident has been assessed to smoke with supervision AND TO WEAR APRON Date Initiated: 05/18/2025.<br><br>The goals of the care plan were documented as:<br><br>o Resident will demonstrate safe smoking practices thru the next review date. Target Date: 08/27/2025.<br><br>o Resident will adhere to the smoking policy daily thru the next review date. Target Date: 08/27/2025.<br><br>Interventions to the care plan included:<br><br>o Smoking Apron to be worn while he smokes for his safety r/t dx [related to diagnosis] seizures.<br><br>o Maintain smoking materials in designated area.<br><br>o Provide assistance with lighting cigarette if needed.<br><br>o Apply/remove smoking apron.<br><br>Review of the Smoking evaluation, dated 09/03/24 documented, the resident:<br><br>Has the cognitive ability to smoke safely.<br><br>Has the visual ability to smoke safely.<br><br>Has the physical dexterity to smoke safely.<br><br>Has the physical ability to smoke safely.<br><br>Does not smoke safely.<br><br>Utilized ashtray safely and properly.<br><br>Resident must be supervised by staff, volunteer, or family member at all times when smoking.<br><br>Must wear smoking apron at all times.<br><br>Must request smoking materials from staff.<br><br>Further review of Resident #6's record revealed that no additional smoking assessment was conducted at least quarterly per facility policy, since 09/03/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review revealed Resident #30 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS with a reference date of 03/20/25, Resident #30 had a BIMS score of 12, indicating the resident was moderately cognitively impaired. The assessment documented that the resident was dependent upon staff for bed mobility, transfers and ambulation via manual wheelchair. Resident #30's diagnoses at the time of the assessment included: CAD, Hypertension, Hyperlipidemia, Aphasia, Seizure disorder, Anxiety disorder, Depression, Need for assistance with personal care, Disorders of muscle, Chronic pain in left shoulder, and Idiopathic peripheral autonomic neuropathy.<br><br>Review of Resident #30's care plan for smoking documented:<br><br>Resident desires to smoke. Resident has been assessed as able to smoke: with supervision due to Cerebro Vascular Accident (CVA) with left hemiparesis. Resident is a chain smoker Date Initiated: 12/31/2021.<br><br>Goals:<br><br>o Resident will demonstrate safe smoking practices thru the next review date. Target Date: 06/19/2025.<br><br>o Resident will adhere to the smoking policy daily thru the next review date. Target Date: 06/19/2025.<br><br>Interventions:<br><br>o Maintain smoking materials in designated area.<br><br>o Accompany resident to designated smoking area and provide supervision if needed.<br><br>o Provide assistance with lighting cigarette if needed.<br><br>o Apply/remove smoking apron.<br><br>o Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed.<br><br>An additional care plan for smoking documented:<br><br>Resident is a smoker. Resident desires to smoke. Resident has been assessed as able to smoke with supervision due to CVA with left hemiparesis. Resident is a chain smoker -12/30/21 smoking Apron when resident smokes for safety. 11/11/22 Resident continues to be non-compliant with smoking policy. He continues to have cigarette paraphernalia despite redirections. 08/23/23- resident is compliant at this time with smoking policy Date Initiated: 11/20/2024.<br><br>The goal of this care plan was documented as:<br><br>Resident will adhere to the smoking policy daily Target Date: 06/19/2025.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interventions of the care plan included:<br><br>o Accompany resident to designated smoking area and provide supervision if needed.<br><br>o Apply/remove smoking apron.<br><br>o Maintain smoking materials in designated area.<br><br>Review of the Smoking Evaluation dated 11/24/24 documented Resident #30:<br><br>Does not have the physical dexterity to smoke safely.<br><br>Does not have the physical ability to smoke safely.<br><br>Does not smoke safely.<br><br>Does not utilize ashtray safely and properly.<br><br>Is not able to extinguish cigarette safely and completely when finished smoking.<br><br>Must be supervised by staff, volunteer, or family member at all times when smoking.<br><br>Must wear a smoking apron at all times.<br><br>Must request smoking materials from staff.<br><br>Further review of Resident #30's record revealed no additional smoking assessment was conducted at least quarterly per facility policy, since 11/24/24.<br><br>3. Record review revealed Resident #36 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS, with a reference date of 03/18/25, Resident #36 had a BIMS score of 15, indicating the resident was cognitively intact. The assessment documented that the resident was independent for bed mobility, transfers and ambulated independently without the use of assistive devices (walker, wheelchair).<br><br>Resident #36's diagnoses at the time of the observation included: Cancer, CAD, Depression, Difficulty in walking, Presence of artificial right shoulder joint, Nicotine dependence, Pain in right shoulder, and Age-related osteoporosis.<br><br>Review of Resident #36's Care plan for smoking documented:<br><br>Resident desires to smoke. Resident has been assessed as able to smoke safely Date Initiated: 07/30/2022.<br><br>The goals of the care plan were documented as:<br><br>o Resident will demonstrate safe smoking practices thru the next review date. Target Date: 08/01/2025.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | o Resident will adhere to the smoking policy daily thru the next review date. Target Date: 08/01/2025.<br><br>Interventions to the care plan included:<br><br>o Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed.<br><br>o Observe for decline in hand dexterity; assist to hold cigarette as needed.<br><br>Review of Resident #36's care plan for tobacco use documented:<br><br>Tobacco Use Date Initiated: 05/01/2024.<br><br>The goals of the care plan were documented as:<br><br>o Resident will not suffer injury from unsafe smoking practices Target Date: 08/01/2025.<br><br>o Resident will Adhere to the Tobacco / Smoking Policies of the Facility Target Date: 08/01/2025.<br><br>Interventions of the care plan included:<br><br>o Conduct Smoking Safety Evaluation on admission and PRN<br><br>o Educate Resident / Responsible Party on the facility's tobacco / smoking policy(s)<br><br>o If a smoking facility, orient Resident to smoking times and procedures<br><br>o The resident requires supervision while smoking.<br><br>Review of the Smoking evaluation, with a reference date of 11/24/24, documented Resident #36:<br><br>Must be supervised by staff.<br><br>Must request smoking materials from staff.<br><br>Further review of Resident 36's record revealed no additional smoking assessment was conducted at least quarterly per facility policy since 11/24/24.<br><br>4. Record review revealed Resident #77 was admitted to the facility with Hospice services on 11/23/24. According to the resident's most recent complete assessment, a Quarterly MDS, with a reference date of 02/28/25, Resident #77 had a BIMS score of 14, indicating the resident was cognitively intact. The assessment documented that the resident required supervision or touching assistance for bed mobility, partial/moderate assistance for transfers, and ambulated with setup or cleanup assistance via manual wheelchair. Resident #77's diagnoses at the time of the assessment included: Cancer, Anemia, Hypertension, Anxiety disorder, Psychotic disorder, Need for assistance with personal care, Muscle weakness, and Nicotine dependence.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Smoking evaluation, with a reference date of 11/27/24, documented Resident #77:<br><br>Was not able to extinguish cigarette safely and completely when finished smoking.<br><br>Must be supervised by staff, volunteer, or family member at all times when smoking.<br><br>Must wear smoking apron at all times.<br><br>Must request smoking materials from staff.<br><br>Review of Resident #77's care plan for smoking documented:<br><br>Resident is a smoker 02/04/25 Resident has been noted at times to be non compliant with Smoking Policy as evident by having cigarettes and lighters on person and in room. Date Initiated: 11/24/2024.<br><br>The goals of the care plan were documented as:<br><br>o Resident will adhere to the smoking policy daily Target Date: 08/28/2025<br><br>o Resident will demonstrate safe smoking practices Target Date: 08/28/2025<br><br>Interventions of the care plan included:<br><br>o 2/4/25 Remind resident of smoking times and smoking area, and that non compliance with Policy may lead to restrictions and possible discharge.<br><br>o Educate resident/responsible party on the facility smoking policy<br><br>o Maintain smoking materials in designated area<br><br>o Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed.<br><br>Further review of Resident 77's record revealed no additional smoking assessment was conducted at least quarterly per facility policy since 11/27/24.<br><br>5. Record review revealed Resident #86 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an admission/Medicare 5-day MDS, with a reference date of 04/22/25, Resident #86 had a BIMS score of 14, indicating the resident was cognitively intact. The assessment documented that the resident required supervision or touching assistance for bed mobility and transfer and partial/moderate assistance for ambulation via manual wheelchair. Resident #86's diagnoses at the time of the assessment included: Chronic Obstructive Pulmonary Disease (COPD), Cancer, CAD, Hypertension, Hyperlipidemia, Anxiety disorder, Depression, Chronic lung disease, Need for assistance with personal care, Muscle weakness, Abnormalities of gait and mobility, Hereditary and idiopathic neuropathy, shortness of Breath (SOB), and Dependence on supplemental oxygen.<br><br>Review of Resident #86's baseline care plan documented:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident is a smoker Date Initiated: 04/18/2025.<br><br>The goals of the care plan were documented as:<br><br>o Resident will adhere to the smoking policy daily Target Date: 07/23/2025<br><br>o Resident will demonstrate safe smoking practices Target Date: 07/23/2025<br><br>Interventions of the care plan included:<br><br>o Accompany resident to designated smoking area and provide supervision if needed<br><br>o Educate resident/responsible party on the facility smoking policy<br><br>o Maintain smoking materials in designated area<br><br>o Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed.<br><br>Review of the Smoking evaluation dated 02//27/25 documented Resident #86:<br><br>Was not able to extinguish cigarette safely and completely when finished smoking.<br><br>Must be supervised by staff, volunteer or family member at all times when smoking.<br><br>Must wear a smoking apron at all times.<br><br>Must request smoking materials from staff.<br><br>6. Record review revealed Resident #399 was admitted for current stay on 05/14/25. According to the resident's most recent complete assessment, a Medicare 5-day MDS, with a reference date of 05/21/25, Resident #399 had a BIMS score of 12, indicating that the resident was moderately cognitively impaired. The assessment documented that the resident required supervision or touching assistance for bed mobility, partial/moderate assistance for transfers, and substantial/maximal assistance for ambulation in manual wheelchair. Resident #399's diagnoses at the time of the observation included: Stroke, Hemiplegia following cerebral infarction, CAD, Depression, Psychotic disorder, Post Traumatic Stress Disorder (PTSD), Chronic lung disease, Contracture to right hand, Colostomy status, Abnormalities of gait and mobility, Muscle weakness, Need for assistance with personal care, Chronic pain, Hereditary and idiopathic neuropathy, and Adjustment disorder with mixed disturbances of emotions and conduct.<br><br>Review of the Smoking evaluation, with a reference date of 05/20/25, documented Resident #399:<br><br>Was not able to extinguish cigarette safely and completely when finished smoking.<br><br>Must be supervised by staff, volunteer, or family member at all times when smoking<br><br>Must wear a smoking apron at all times<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Must request smoking materials from staff<br><br>An interview was conducted on 06/03/25 at 12:04 PM, with the Activities Director who was asked about Resident #6 and Resident #30. She stated that when they get out of bed they come down to smoke. If they stay in bed they would not come down to smoke. When asked about the smoking materials, she said they are kept in a safe in the downstairs nursing station.<br><br>An observation was conducted on 06/04/25 at 9:40 AM, of 5 residents, including Residents #6, # 86, #77 and #399, on the smoking patio, with supervision by Staff H, Activities, Certified Nursing Assistant (CNA), here for 4 months. When asked about the residents that she was supervising, Staff H was not sure of the names of the residents that she was supervising. None of the residents were provided aprons. There were 4 aprons observed hanging from hooks on the patio.<br><br>An interview was conducted on 06/04/25 at 9:57 AM with Staff H, Activity Assistant, who when asked about the smoking materials, she stated they are kept locked. She showed the surveyor the locked box on the table. When asked to identify the residents, she was unable to name all of the residents but identified them by what she thought their room number was.<br><br>On 06/04/25 at 3:20 PM, Resident #36 was observed in the courtyard that is the designated smoking area. Resident #36 lit a cigarette and placed the lighter and cigarettes back into a pocket.<br><br>On 06/05/25 at 9:29 AM, Resident #77 was observed in the designated smoking area with supervision provided by Staff H. It was noted the resident was not provided a smoking apron and that there were 4 aprons observed hanging from a hook.<br><br>On 06/05/25 at 9:35 AM, the Activities Director relieved Staff H. The residents were not offered or provided aprons.<br><br>On 06/05/25 at 9:47 AM, Resident #86 arrived to the patio and was given smoking materials by the Activities Director. The resident was not offered or provided an apron.<br><br>On 06/05/25 at 9:55 AM, Resident #399 arrived to the patio and was not offered or provided an apron.<br><br>An interview was conducted on 06/05/25 at 9:58 AM with Residents #6, #86 and #399, in the designated smoking area. When asked about smoking, Resident #86 stated the smoking times were 9:30, 11;00, 1:00, 4:00 and 7:00. When asked about being provided smoking aprons, all of the residents stated that they were not offered or provided, despite them hanging on the wall in the smoking area.<br><br>On 06/05/25 at 1:01 PM, it was observed that Resident #36 arrived to the patio and pulled a cigarette from his sling and a lighter from his pocket and lit the cigarette without assistance from staff. Residents #86 and #399 were observed on the patio with supervision provided by Staff H. They were not provided aprons.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 06/05/25 at 1:10 PM, with the Activities Director, who when asked about providing aprons to the residents, the Activities Director replied, these are the independent ones - the patients are high functioning. The Activities Director further stated that the residents did not require smoking aprons. When asked about maintaining smoking materials for the residents, the Activities Director replied, I make sure that they don't have cigarettes and a lighter with them. I do the smoking twice a day. We get the cigarettes and lighter from them. When asked about Resident #36 having his own smoking materials on his person, the Activities Director replied, when we see that, we grab the book and educate them to the policy. If I would have seen him, I would go over the policy again and have them sign it. Anyone that breaks the policy can get in trouble - the administrator that used to be here would talk to them about the policy and schedule.<br><br>An interview was conducted on 06/05/25 at 1:40 PM, with Resident #36, who when asked about keeping smoking materials on his person, Resident #36 replied, when I am out here (on the patio), I keep them in my pocket. When I am not out here, I keep them in my drawer. It's because I used to have 4 packs at a time in the box and they would not last very long because the CNAs would give them to other people. I am able to take care of myself and keep my own cigarettes and lighter.<br><br>An interview was conducted on 06/06/25 at 8:20 AM, with Resident #30, who when asked about smoking, Resident #30 replied, As much as I can. When asked about being provided a smoking apron every time, Resident #30 stated that the facility did not provide any. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews and record reviews, the facility failed to obtain a urology consultation timely for 1 of 3 sampled residents reviewed for urinary care, Resident #52.<br><br>The findings included:<br><br>Record review revealed Resident # 52 was admitted on [DATE] with diagnoses that included Quadriplegia, Paraplegia, Neuromuscular Dysfunction of Bladder, Gastroesophageal Reflux Disease without Esophagitis, and Anemia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE] under Section C of the Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating Resident #52 had intact cognitive function. Section H dated 03/05/25 revealed the resident had an indwelling catheter (Foley).<br><br>Review of the physician orders dated 02/27/25 revealed an order to monitor the urinary catheter for impairment of drainage every shift.<br><br>Review of the urine culture dated 04/18/25 revealed the resident had acquired Extended Spectrum Beta-Lactamase (ESBL) (a type of enzyme produced by certain bacteria that makes them resistant to a wide range of antibiotics).<br><br>Review of the nursing progress notes dated 04/21/25 at 11:24 PM revealed an order for Bactrim DS, 160 mg (milligram), oral tablet, to give 1 tablet by mouth, 2 times a day for urinary tract infection (UTI) for 5 days.<br><br>Review of the nursing progress notes dated 05/02/25 at 6:25 PM revealed Resident #52's primary physician was called by the Wound Care Nurse who documented that Resident #52 was not feeling well, was with foul smelling urine and had urine sedimentation in the urinary bag. At 8:08 PM, the nurse received an order for Intravenous medication of Ceftriaxone Sodium, 1 gram (G), for UTI for 7 days (antibiotic).<br><br>Additional review of the physician progress notes dated 05/16/25 revealed, under assessments, that Resident #52 had Proteus Mirabilis ESBL UTI, Complicated UTI, Acute Kidney Injury (AKI), Hematuria, and Paraplegia requiring full care. Review of this plan revealed the facility was to follow up with an urologist consultation.<br><br>Review of progress notes did not revealed there was a urologist consultation or a urologist visit.<br><br>Review of the primary physician progress notes dated 05/23/25 revealed Resident#52 was examined, had bloodwork done, the laboratory results were reviewed, and the physician agreed with the Nurse Practitioner's assessment and plan of care for a urology consult.<br><br>Review of progress notes did not revealed there was a urologist consultation or a urologist visit.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with Resident #52 on 06/06/25 at 2:00 PM, who when he was asked regarding his past antibiotic treatment and painful urination, he stated he received antibiotics but had never seen any urologist. When asked if it was important for him to see a urologist, he responded, The Nurse Practioner told me that she ordered a urologist consult, but I do not know when is the urologist going to see me He stated that he needed help in transporation to see a urologist since he cannot easily move his upper and lower extremities without full assistance from facility staff. When asked if any staff informed him of any urologist appoitnment, he responded, No one told me anything about a urologist.<br><br>An interview was conducted with Staff J, Licensed Practical Nurse (LPN), on 06/06/25 10:44 AM, who when asked if the resident had seen a urologist, she stated she did not know.<br><br>An interview was conducted with the Assistant Director of Nursing (ADON) on 06/06/25 11:00 AM, who when asked regarding a urologist consult, she stated that it depends on resident's insurance. As soon as the insurance is approved, the resident would be scheduled with the urologist. When asked if any urologist consult was requested for Resident #52 since April 2025 , she stated she would check. Until the end of the survey, no information regarding a urologist consult for Resident # 52 was provided.<br><br>Review of progress notes did not revealed there was a urologist consultation or a urologist visit. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893<br><br>Based on observations, interviews and record reviews, the facility failed to follow physician ordered fluid restrictions for 1 of 1 sampled resident reviewed who had physician ordered fluid restrictions, Resident #38.<br><br>The findings included:<br><br>Record review revealed Resident #38 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual Minimum Date Set MDS) assessment, with a reference date of 05/14/25, Resident #38 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident #38's diagnoses at the time of the assessment included: Post polio syndrome, Anemia, Coronary Artery Disease, Hypertension, Gastro Esophageal Reflux Disease, Benign Prostatic Hyperplasia, Renal Insufficiency, Neurogenic Bladder, Obstructive Uropathy, Urinary Tract Infection (in the previous 30 days), Arthritis, Seizure disorder, Depression, and Muscle Weakness.<br><br>Review of the physician orders for Resident #38's included the following:<br><br>Fluid Restriction: 2 LITERS q 24H [every 24 hours]. Dietary to provide a total of 1250 ML/24H, Nursing to provide a total of 750 ML/24H: 7-3 shift: 250 ML/24H, 3-11shift:250 ML/24H, 11-7shift: 250 ML/24H - 05/08/25.<br><br>Review of Resident #38's care plan for hydration documented:<br><br>Resident is at risk for alteration in hydration status related to: Diuretic medication use 5/8/25 Re-admit diagnoses of Sepsis/Complicated UTI, Acute kidney incident. On Fluid restriction. Date Initiated: 05/13/2021.<br><br>The goal of the care plan was documented as:<br><br>Resident will maintain adequate hydration through next review date. Target Date: 08/28/2025.<br><br>Interventions of the care plan included:<br><br>o Honor food/fluid preferences.<br><br>o Observe resident for deviation from fluid restriction; educate resident of consequences as needed.<br><br>Review of Resident #38's care plan for alteration in elimination documented:<br><br>Resident has an alteration in elimination as evidenced by bowel incontinence and diagnoses: Benign prostatic hyperplasia. At risk for UTI related to Foley Catheter use and history of recurrent UTI's . Fluid restriction.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The goals of the care plan were documented as:<br><br>o Resident will be clean, dry, and odor free daily thru the next review date. Target Date: 08/28/2025.<br><br>o Resident will remain free from signs/symptoms of UTI thru the next review date. Target Date: 08/28/25.<br><br>Intervention of the care plan included:<br><br>o Fluid restriction as ordered<br><br>Review of Resident #38's care plan for pain documented:<br><br>Resident has a potential for pain and/or alteration in comfort related to diagnoses: Post-polio Syndrome. Neuromuscular deconditioning.<br><br>The goals of the care plan were documented as:<br><br>o Resident will voice an acceptable level of comfort thru the next review date. Target Date: 08/28/2025<br><br>o Resident will exhibit signs/symptoms that pain is at an acceptable level of comfort thru the next review date. Target Date: 08/28/2025<br><br>Interventions:<br><br>O Encourage adequate fluid intake and observe for signs/symptoms of constipation; notify physician as indicated<br><br>An interview was conducted on 06/04/25 at 7:52 AM with Resident #38 who stated he was aware of fluid restrictions because he has a catheter and can drink all of the water that he wanted. The resident was noted with a 16 ox (ounce) cup of water on his overbed table that appeared to be fresh as evidenced by the wrapper was still on the straw that was placed in the lid of the cup.<br><br>On 06/04/25 at 1:46 PM, Resident #38 was observed in bed with a 16 oz cup of fluid on his overbed table with lunch tray. It was noted that the cup of fluid was approximately half full of fluid.<br><br>On 06/05/25 at 8:48 AM, Resident #38 was observed in bed with breakfast on overbed table. The resident was noted to have a 16 oz cup of water on the nightstand to the resident's right side of the bed. Resident #38 stated that water is refreshed, every morning and sometimes in the afternoon.<br><br>An interview was conducted on 06/05/25 at 1:02 PM with Staff I, Certified Nursing Assistant (CNA), who when asked about providing fluids to the residents, Staff I replied, after breakfast I check on them and after lunch, I check to see if they need to be refreshed. Sometimes we put more and check more when it is hot and they have been outside. When asked about being aware of Resident #38 having fluid restrictions, Staff I replied, They never told me about the fluid restrictions. He tries to drink more so that he can pee.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 06/06/25 at 7:58 AM with the Assistant Director of Nursing (ADON) who when asked about Resident #38's fluid restrictions, the ADON replied, we sent him to the hospital 05/08/25 for retaining urine, he came back from the hospital with a Foley catheter and with an order for fluid restrictions. He will be retaining fluid. He has the order, so we encourage him to maintain the fluid restrictions. We educated him to follow the current diet order. We don't want him to have heart failure. When we sent him out, it was because he wasn't avoiding, he was retaining urine, and he had an altered mental status. His abdomen was distended. We did a urine culture, and he was having altered mental status and came back with the catheter. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on interview and record review, the facility failed to adequately monitor behaviors and side effects of medications for residents receiving psychotropic medications for 3 of 5 sampled residents reviewed for unnecessary medications, Residents #69, #9, and #79.<br><br>The findings included:<br><br>Review of the facility's policy titled, Behavioral Assessment, Intervention and Monitoring with a date of 2001, included in part the following: The facility complies with regulatory requirements related to the use of psychotropic medications. The IDT (interdisciplinary team) monitors for and documents any new, worsening, or improved symptoms in the resident's behavior, mood, and function.<br><br>1. Record review revealed Resident #69 was originally admitted to the facility on [DATE] with most recent readmission on 08/18/24 with diagnoses that included in part the following: Cerebral Infarction, Cognitive Communication Deficit, Problem Related to Unspecified Psychosocial Circumstances, Unspecified Psychosis, Anxiety Disorder, Unspecified Dementia, Other Persistent Mood Disorders, Brief Psychotic Disorder, and Major Depressive Disorder Recurrent.<br><br>The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C, a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment.<br><br>Review of the Physician's Orders for Resident #69 revealed the following orders:<br><br>An order dated 08/18/24 for Medication Management: Diagnosis Psychosis 0= no behavior 1= Combativeness 2= Verbally inappropriate 3= Sexually inappropriate 4= Disrobing 5= Crying excessively 6= Calling out constantly 7= Screaming excessively 8= Auditory Hallucinations 9= Delusional 10= Resists Care 11= Socially inappropriate 12= Extreme Pacing 13= Restlessness 14= Other every shift for monitor.<br><br>An order dated 08/18/24 for Side effects related to psychoactive medication: 0= None 1= movement side effects 2= non-movement side effects every shift for monitoring.<br><br>An order dated 08/18/24 for Trazodone HCl Oral Tablet 100 MG give 1 tablet by mouth three times a day.<br><br>An order dated 05/16/25 for Memantine HCl Oral Tablet 10 MG give 1 tablet by mouth two times a day.<br><br>An order dated 05/23/25 for Behavior Code- Depression 0=No Behavior 1=Fear/Panic 2=Anger 3=Scream/Yell 4=Danger/Self/Others 5=Delusions 6=Hallucinations 7=Sad/Tearful 8=Emotional withdrawal/Withdrawal act. 9=Other(describe) Interventions- 1=Music, aromatherapy 2=Reminiscence, reality orientation 3=Exercise, act. 4=1:1 5=Reduce Stim 6=PRN given Outcome- I=Improved S=Same W=Worse Side Effects- 0=None 1=EPS 2=Tardive Dyskinesia 3=Hypotension 4=Inc. behavior 5=Sedation/drowsiness 6=Inc. falls/dizziness every shift.<br><br>Review of the Behavior Monitoring Flow Sheet from 05/14/25 to 05/31/25 revealed no documentation of behaviors or side effects as follows:<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/14/25, no documentation for day, evening or night shift.<br><br>On 05/15/25, no documentation for day shift.<br><br>On 05/20/25, no documentation for night shift.<br><br>On 05/22/25, no documentation for day shift.<br><br>On 05/23/25, no documentation for day shift.<br><br>On 05/28/25, no documentation for day or night shift.<br><br>On 05/29/25, no documentation for day shift.<br><br>Review of the care plans for Resident #69 dated 04/12/25 revealed a focus on the resident has the potential for adverse side effects related to the use of psychotropic medications: antidepressant for treatment of Depression and antipsychotic for treatment of Psychosis and Brief Psychotic Disorder. The goals were for the resident to receive the lowest effective dose of psychotropic medication to ensure maximum functional ability and to remain free from adverse side effects related to use of psychotropic medications thru the next review date. The interventions included in part the following: Observe for effectiveness of psychotropic medications. Observe for changes in mood/behavior; report to physician if noted.<br><br>An interview was conducted on 06/04/25 at 2:45 PM with Staff G, Licensed Practical Nurse (LPN), who stated she has worked at the facility for 6 years. When asked if they monitor for behaviors and side effects for residents who are prescribed psychotropic medications, Staff G LPN said 'yes, they monitor for both behaviors and side effects every shift'. When asked if they document this, the LPN stated they document the findings on the Behavior Flow Sheet for the resident in the electronic chart.<br><br>An interview was conducted on 06/05/25 at 9:10 AM with the Assistant Director of Nursing / Infection Preventionist (ADON/IP) who was asked about monitoring behaviors and side effects for residents receiving psychotropic medications. She said they do monitor for behaviors and side effects each shift. When asked about Resident #69, the ADON/IP acknowledged there were several shifts with no documentation for behaviors and side effects.<br><br>39167<br><br>2. Record review revealed Resident #9 was admitted to the facility on [DATE] with a diagnosis of Hypertension. The admission Minimum Data Set (MDS) assessment, conducted on 03/31/25, included a BIMS score of 15, which indicated the resident was cognitively intact.<br><br>On 03/26/25, the physician orders for medication management were documented. The following rating scale was used to assess behavior related to antidepressant medication:<br><br>- 0 = No behavior<br><br>- 1 = Combativeness<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 2 = Verbally inappropriate<br><br>- 3 = Sexually inappropriate<br><br>- 4 = Disrobing<br><br>- 5 = Crying excessively<br><br>- 6 = Calling out constantly<br><br>- 7 = Screaming excessively<br><br>- 8 = Auditory hallucinations<br><br>- 9 = Delusional<br><br>- 10 = Resists care<br><br>- 11 = Socially inappropriate<br><br>- 12 = Extreme pacing<br><br>- 13 = Restlessness<br><br>- 14 = Other<br><br>The following medications were prescribed:<br><br>- On 04/01/25, Mirtazapine oral tablet 7.5 mg, to be taken one tablet by mouth at bedtime for major depressive disorder.<br><br>- On 04/01/25, Nortriptyline oral capsule 75 mg to be taken one capsule by mouth at bedtime for major depressive disorder.<br><br>Review of the baseline care plan, dated 03/26/25, noted that Resident #31 had the potential for adverse side effects related to the use of psychotropic medications, specifically antidepressants, in the treatment of depression. The care plan included the following interventions: observe the effectiveness of the psychotropic medications, monitor for any adverse side effects related to their use, and report any changes in mood or behavior to the physician.<br><br>Review of the medication and treatment administration records for May 2025 revealed a lack of documented evidence for medication management of the antidepressants on the following days: May 1, May 9, May 18, May 22, May 25, and May 30, 2025.<br><br>50370<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Record review revealed Resident #79 was admitted on [DATE] with diagnoses including Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD), Generalized Anxiety Disorder and Major Depressive Disorder.<br><br>Review of MDS assessment dated [DATE] under Section C of the BIMS revealed a score of 15 indicating Resident #79 had intact mental cognition.<br><br>Review of the physician order dated 03/26/25 revealed an order for Trazodone 100 milligram (mg), to give one (1) tablet by mouth at bedtime for depression.<br><br>An additional review of a physician order dated 05/20/25 revealed an order for Alprazolam 0.5 mg to give 1 tablet b y mouth three times a day for anxiety.<br><br>Review of the physician progress notes dated 06/03/25 revealed Resident #79 was dealing with mobility issues, fracture from recent fall, respiratory failure, and intense feelings of anxiety and reported depression as responses to adjusting to limitations, and life changes.<br><br>Review of the care plans revealed the following goals: the resident will receive the lowest effective dose of psychotropic medications to ensure functional ability; the resident will remain free from adverse side effects related to the use of psychotropic medications. The interventions included observing changes in mood, behavior, and reporting changes to the physician.<br><br>Review of the May 2025 Behavior Monitoring Record (BHR) revealed the following: no documentation of anti-anxiety intervention codes on 05/09/25, and on 05/17/25 during day, evening and night shifts; no documentation on 05/20/25 during the evening and night shifts, and on 05/26/25, there was no documentation on the day shift.<br><br>An interview ws conducted with the Assistant DON on 06/05/25 at 2:00 PM who when asked if residents receiving psychotropic medications are monitored, she responded, Yes, we monitor for the side effcets of the psychotropic medications in the Medication Adminsitration Record (MAR). She stated staff also monitor residents' behavior and the codes for the resident's presented behavior are docuemented by staff nurses in MAR. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure the medication error rate was not 5% or greater. The medication error rate was 18.75% with 6 medication errors identified while observing a total of 32 opportunities, affecting Resident #43 and Resident #86.<br><br>The findings included:<br><br>Review of the facility's policy, titled, Adverse Consequences and Medication Errors, with a revised date of April 2014, included in part the following:<br><br>A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacture specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medication errors include omission - a drug is ordered but not administered, unauthorized drug - a drug is ordered but not administered, wrong time.<br><br>1. Record review for Resident #43 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 05/30/25 with diagnoses that included in part the following: Protein-Calorie Malnutrition, Dementia, and Sepsis. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 9 indicating moderate cognitive impairment.<br><br>Review of the Physician's Orders for Resident #43 revealed an order dated 05/30/25 for Florastor Oral Capsule 250 MG (Saccharomyces boulardii, type of Probiotic) give 1 capsule by mouth one time a day for digestive health for 10 Days and was discontinued on 06/05/25. In summary, there was no current order for Lactobacillus 250mg.<br><br>During medication (med) pass observation conducted on 06/05/25 at 8:40 AM with Staff A, Licensed Practical Nurse (LPN), for Resident #43, administered meds to include Lactobacillus 250mg given orally.<br><br>An interview was conducted on 06/05/25 at 8:45 AM with Staff A who stated she has worked at the facility for 2 years. When asked about the Lactobacillus 250mg administered to Resident #43 when in fact the resident had an order for Florastor Oral Capsule 250 MG (Saccharomyces boulardii), she said it was the facility uses, it is the same thing.<br><br>An interview was conducted on 06/05/25 at 8:50 AM with the Assistant Director of Nursing (ADON) who was asked about Resident #43 and receiving Lactobacillus 250mg instead of the prescribed Florastor Oral Capsule 250 MG (Saccharomyces boulardii), the ADON stated it is the same thing. Later the ADON returned to this surveyor and clarified that the 2 medications were similar, but not the same.<br><br>50370<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Record review revealed Resident #86 was admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation, Malignant Neoplasm of unspecified part of the bronchus or lungs, Major Depressive Disorder and Essential Primary Hypertension.<br><br>Review of recent Minimum Data Set (MDS) assessment dated [DATE] under Section C for the BIMS revealed a score of 14 indicating Resident # 86 had intact cognitive function.<br><br>Review of the physician orders revealed the following orders:<br><br>On 05/20/25, Alprazolam 0.25 milligram (mg), to give one (1) tablet by mouth every twelve (12) hours for Anxiety Disorder;<br><br>On 04/18/25, Amlodipine Besylate five (5) mg, to give 1 tablet by mouth one time a day for Hypertension, to hold for systolic blood pressure less than 110, and heart rate less than 60;<br><br>On 04/26/25, Sertraline 25 mg, to give 1 tablet by mouth 1 time a day for Depression and Anxiety;<br><br>On 04/21/25, Losartan Potassium 50 mg, to give 1 tablet by mouth 1 time a day for Hypertension, to hold for systolic blood pressure less than 110 or heart rate less than 60; and<br><br>On 04/21/25, Icosapent Ethyl capsule1 gram (Gm), to give 1 capsule by mouth 2 times a day for Hyperlipidemia.<br><br>Review of nursing care plans included goals to prevent potential complications related to alteration in cardiac function, revealed to the administer medications as ordered.<br><br>During medication administration pass on 06/04/25 at 10:56 AM, Staff A, Licensed Practical Nurse (LPN), stated she was going to administer the medications late for Resident #86 because she had to discharge another resident.<br><br>Staff A prepared the medication after taking Resident #86's vital signs including a blood pressure of 145/53 and a heart rate of 66 beats per minute. She prepared Alprazolam 0.25 mg, Amlodipine5 mg, Sertraline 25 mg, Losartan 50 mg and Icosapent 1 gm. Staff A administered the above medications at 11:15 AM.<br><br>Review of the MAR revealed all the above medications were documented as administered at 9:00 AM, with check marks and Nurses initials. There were no progress notes written regarding the above medications that were administered late and the reason why.<br><br>In an interview and record review of time stamped MAR submitted by the Assistant Director of Nursing (ADON), she revealed that all the above medications were administered after 9:00AM, from 9:56 AM to 11:11 AM.<br><br>In a continuing interview with the ADON on 06/05/25 at 10:00 AM she stated, One (1) hour before and 1 hour after the scheduled time is acceptable. If the medication was not administered on time, the nurse must use code 9 for MAR documentation, which means other, or see Nurse's note. The nurse must write the reason why the medications were administered late.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The ADON further stated that two (2) hours after the scheduled time is considered late if following the facility's policy. She added the nurse should have documented that it is late and used code 9 indicating to see progress notes. In progress notes, the nurses must document why the medications were administered late. Some reasons the nurses usually document are the resident was on therapy or at a doctor's appointment.<br><br>When she was asked if the nurses were documenting late medication administration, she stated, No, we do monthly Quality Assurance and Process Improvement (QAPI), and there were no incidences of late medication administration. |

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|---|---|---|---|
| | 105125 | A. Building<br>B. Wing | 06/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Terraces of Lake Worth Care Center and Rehab | 1711 6th Avenue South<br>Lake Worth, FL 33460 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167<br><br>Based on observation, interview, and record review, the facility failed to ensure that physician visit notes were made part of the residents' records for 1 of 1 sampled resident who voiced concerns regarding physician services, Resident #9.<br><br>The findings included:<br><br>Record review revealed Resident #9 was admitted to the facility on [DATE] with a diagnosis of Hypertension. The admission Minimum Data Set (MDS) assessment, conducted on 03/31/25, included a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact.<br><br>Clinical record review indicated that the Advanced Practitioner Registered Nurse (APRN) visited Resident #9 on the following dates: 03/26/25; 03/27/25; 04/02/25; 05/09/25; 05/19/25; and 05/29/25. There was no documented evidence of the attending physician visiting Resident #9 at the facility.<br><br>On 06/03/25 at 10:55 AM, an interview was initiated with Resident #9. She said that she had been at the facility for approximately three months and had not seen the attending physician. She had only been seen by the APRN. She stated, My legs are discolored. No one can tell me what is wrong with them; this morning, I had to call my primary doctor to make an appointment. Resident #9 was visibly upset. At 11:00 AM, the APRN abruptly entered the room during the surveyor's interview with the resident. Resident #9 immediately showed her legs and inquired about the discoloration. The APRN dismissed her concerns, stating, Someone else will address that, and left the room, promising to return later.<br><br>On 06/05/25 at 10:43 AM, an interview was conducted with the Assistant Director of Nursing (ADON). When asked about physician visits and the frequency with which the attending physician visits the residents, she stated that he comes every day, possibly two to three times a week, but admitted she was unsure. She left to consult the Regional Nurse Consultant for clarification. At 11:02 AM, the ADON returned with the Regional Nurse Consultant. When asked how often residents should be seen by the attending physicians, the consultant replied that they should be seen every 30 days for the first 90 days and then every 60 days thereafter, allowing for a 10-day grace period and visits as needed. She added that the APRN could alternate visits with the physician. Upon admission, the physician is required to see the residents. When asked who was responsible for ensuring that physician visits were completed, the Regional Nurse Consultant stated that the clinical team leader, the Director of Nursing (DON), was responsible for reminding the physicians about their visits.<br><br>The Regional Nurse reviewed Resident #9's records and noted that she could not find any visit notes from the attending physician.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 11:20 AM, the Regional Nurse called the attending physician and placed him on speakerphone. He stated, I visit the residents about once a month, sometimes more frequently or as needed. The building has Nurse Practitioners, and the residents are seen by the Nurse Practitioners more often than him. When asked where he documented his visits to the computer system, he explained that he uses his own electronic medical record (EMR) as he feels more comfortable with it. He tries to upload visit notes to the facility's computer system after completing them but admitted he has fallen behind, stating, That's my deficiency. He mentioned that he has been busy and hasn't had the opportunity to upload visit notes for some time, noting that he is behind by about a year. The physician promised to submit the visit notes for Resident #9 by the end of the day.<br><br>On 06/05/25 at 1:10 PM, it was noted that the physician had uploaded his visit notes for Resident #9 under the miscellaneous category for several visits dated 03/25/25; 04/11/25; 04/21/25; 05/07/25; and 05/25/25. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on observations, interviews and record reviews, the facility failed to ensure it implemented its Infection Control program as evidenced by failure to follow the Center for Disease Control and Prevention (CDC) guidelines for 1 of 19 sampled residents with Enhanced Barrier Precautions (EBP) protocol, Resident #398; failure to follow the facility's policy to properly disinfect the vital signs monitoring cart after use for 1 of 24 sampled residents during a medication pass observation in the unit, Resident #86; and failure to maintain urinary catheter drainage bag off the floor for 2 of 3 sampled residents reviewed for catheters, Resident #37 and Resident #72.<br><br>The findings included:<br><br>Review of the Center for Disease Control and Prevention (CDC) Enhanced Barrier Precautions guidelines revealed in part the following: Everyone must clean their hands, including when both entering and leaving the room: Providers and Staff must also wear gloves and a gown for the following; high-contact care resident care activities, dressing, bathing-showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting: Device care or use; central line, urinary catheter, feeding tube, tracheostomy: Wound care with any skin opening requiring a dressing.<br><br>Website: https://www.cdc.gov/long-term-care facilities/media/pdfs/<br><br>Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, undated, revealed resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the Occupational Safety and Health Administration (OSHA) Blood borne Pathogens standards.<br><br>Noncritical resident care items including bedpans, and blood pressure cuffs will be disinfected by intermediate and low-level disinfectants like ethyl or isopropyl alcohol, sodium hypochlorite, phenolic germicidal agents and iodophor germicidal agents, and quaternary ammonium germicidal detergents (low-level disinfection only), (c1, 2-a). Reusable items are cleaned and disinfected between residents (e.g. stethoscopes, durable medical equipment), (5).<br><br>Review of the facility's policy titled, Catheter Care, Urinary, undated, revealed under infection control to be sure the catheter tubing and drainage bag are kept off the floor (no. 2).<br><br>1. Record review revealed Resident #398 was admitted on [DATE] with diagnoses that included Heart Failure, Atrial Fibrillation, [NAME] Syndrome, and Essential Primary Hypertension.<br><br>Review of the admission Minimum Data Set (MDS) assessment revealed it is still in progress.<br><br>Review of the physician orders dated 05/30/25 and 05/31/25 for physical therapy (PT) and occupational therapy (OT) revealed the following: PT to evaluate and treat 5 times a week, for 4 weeks for therapeutic exercises, neuro re-education, gait training, and wheelchair management; OT to continue 5 times a week for 30 days for exercises, neuro- re-education, wheelchair management and self-care.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An additional review of physician orders dated 06/02/25 revealed to cleanse the skin tears on the left lateral knee, the left anterior knee, and the anterior and lateral sides of the right knee with normal saline, apply xeroform and cover with dry protective dressings.<br><br>Further review of physician orders revealed the following: cleanse the moisture - associated skin damage (MASD) on the left and the right shoulders (under the axillae), with normal saline, and apply zinc oxide each day shift.<br><br>An observation was conducted on 06/04/25 at 10:37 AM, with Staff B, Physical Therapy (PT), who came inside Resident #398's room and told this resident, It is time to go. Staff B did not perform hand hygiene before entering the room. He was observed putting on gloves while talking with Resident #398. The resident was observed with dressings on the left anterior and lateral knee and leg. Outside the room was an EBP sign posted above the 2 residents' names.<br><br>When Staff B was asked if the resident is under EBP protocol, Staff B responded, No. When he was asked about EBP, he responded, I do not know the EBP status of the resident. On 06/04/25 at 10:43 AM, Staff B removed his gloves after transferring the resident from bed to wheelchair and did not sanitize his hands or perform hand hygiene after removing his gloves. Staff B wheeled the resident out of the room. The surveyor showed him Resident #398's dressings on the knees and the left leg which were visible since the resident was wearing shorts. This staff responded, Oh.<br><br>An interview was conducted with Staff A, Licensed Practical Nurse (LPN), on 06/04/25 at 10:42 AM, who when asked how staff would verify the EBP status of a resident based on the EBP sign above the residents' names at the door, she responded, The EBP post will have an additional circular sticker with a letter W, indicating the EBP protocol is for the resident on the window. If the sticker is marked with D, it means the resident on the door side is under EBP protocol.<br><br>An observation was conducted on 06/06/25 at 11:00 AM, with Staff F, Certified Nursing Assistant (CNA), who was changing the bed linens of Resident #398. Staff F was wearing only gloves, but no gown. When she was asked about the EBP protocol for this resident, she pointed at her gloves.<br><br>An interview was conducted with the Infection Preventionist (IP) on 06/06 25 at 11:28 AM, who stated staff were in-serviced regarding putting on PPE gowns and gloves during transferring and changing bed linens of residents, especially during residents' care requiring 10 to 15 minutes of direct care-contact. She added that the facility follows the CDC guidelines for EBP.<br><br>An interview was conducted with Staff C, PT, on 06/06/25 at 9:00 AM, who when asked how he determines which resident in an EBP room and what is the protocol to be followed for, responded, I usually check the resident's records first. I am a new hire, so I was newly in-serviced regarding EBP. He stated that in an EBP room, PPE like gown and gloves must be worn when transferring residents from bed to wheelchair.<br><br>2. Record review revealed Resident # 86 was admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation, Malignant Neoplasm of unspecified part of unspecified Bronchus or Lung, Major Depressive Disorder, and Recurrent, Moderate Essential Primary Hypertension.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the MDS assessment dated [DATE] under Section C of the BIMS score revealed a score of 14 indicating Resident #86 had intact cognitive function.<br><br>During a medication pass observation on 06/04/25 at 10:56 AM, Staff A, LPN, brought the vital signs cart inside Resident # 86's room. She did not disinfect the blood pressure (BP) cuff and cord before applying it to resident's arm. She was observed clipping the pulse oximeter to resident's finger, then immediately removed it and disinfected it with a wipe. She did not wait for the disinfectant's drying time and immediately clipped the device back on resident's finger. After using the pulse oximeter device and the BP cuff, she removed the cart from Resident #86's room, but did not perform disinfection. She was observed parking it next to her medication cart. She was observed for more than 10 minutes but she had not disinfected the BP cuff and the pulse oximeter clip.<br><br>An interview was conducted with Staff A on 06/04/25 at 11:15 AM, who when asked why she disinfected the pulse oximeter but not the blood pressure cuff before use, she did not respond. When asked how long the drying time is for the disinfectant wipe she used on the pulse oximeter device, she responded, The facility does not tell you what the drying time is. I must check it myself. She was observed to read the instructions on the disinfectant wipe container but never told the surveyor the drying time.<br><br>An interview was conducted with Staff G, LPN, on 06/05/25 at 12:05 PM, who when asked about the drying time for the disinfectant she had inside the medication cart, she responded, The Micro Dot bleach wipes drying time is three (3) minutes. Staff G stated that when she is disinfecting the Assure glucometer with the cleaning wipes, she allowed it to dry for 10 minutes.<br><br>An interview was conducted with the IP on 06/06/25 at 11:28 AM, who she stated the facility uses an alcohol-based wipes for disinfecting general use residents' vital signs monitoring devices such as the blood pressure cuffs, and the pulse oximeter devices. When she was asked the drying time for the commonly used disinfectant, she responded, Since we have different supplies, I recommended to the staff to follow the manufacturer's guidelines. When she was asked for the common names of the most used disinfectants in the facility, she responded, I must check. I do not know the names of the disinfectants.<br><br>3. Record review revealed Resident # 37 was admitted on [DATE] with diagnoses that included Cerebral Atherosclerosis, Cerebral Infarction, and Chronic Kidney Disease Stage 3.<br><br>Review of the most recent MDS assessment under Section C revealed a BIMS score of 00 indicating severely impaired mental cognition.<br><br>Review of the physician orders dated 11/13/24 revealed to change urinary bag and tubing as needed for blockage and signs of infections every night shift, every 14 days, for prophylaxis and as needed.<br><br>An observation on 06/03/25 at 9:57 AM of Resident #37's urinary tubing revealed whitish particles and cloudy urine. The urinary bag was observed on the floor. Staff C, CNA, came in and checked on the resident but did not manipulate the urinary bag to get it off the floor. When Staff C was asked about the urine color, she responded, It looked ok. When asked if caring for urinary tubing and urinary bag were part of her resident's care, she responded, Yes.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation on 06/03/25 at 2:00 PM revealed Resident #37's urinary bag remained on the floor, but Staff F, CNA did not take the urinary bag off the floor during this observation.<br><br>An additional observation on 06/04/25 at 12:00 PM revealed the urinary bag was observed lying on the floor.<br><br>41837<br><br>4. Record review for Resident #72 revealed the resident was originally admitted to the facility on [DATE] with a readmission on 05/22/25 with diagnoses that included in part the following: Neuromuscular Dysfunction of Bladder Unspecified. Review of the MDS assessment dated [DATE] documented in Section C a BIMS score of 15 indicating an intact cognitive response.<br><br>Review of the Physician's Orders for Resident #72 revealed in part the following:<br><br>An order dated 05/22/25 to Monitor urinary catheter for impairment of drainage flow every shift for prophylaxis.<br><br>An order dated 05/22/25 for Catheter care with soap and water every shift and as needed.<br><br>Review of the care plans for Resident #72 with an initiated date of 04/12/25 and the most recent revised date of 05/23/25 with a focus on the resident has a urinary device in place revealed: Foley catheter for diagnosis of Neurogenic Bladder. At risk for UTI (Urinary Tract Infection). The goal was for the resident to maintain adequate urinary elimination via urinary device and will be free of complications related to use of urinary device. The interventions included in part the following: Catheter care every shift and as needed. Staff to provide assistance as needed with management of urinary device.<br><br>On 06/03/25 at 10:20 AM, an observation was made of Resident #72 lying in bed with the urinary catheter drainage bag on the floor propped up against frame of bed.<br><br>An interview was conducted on 06/03/25 at 10:20 AM with Resident #72 who was asked about catheter care. He said they wash his catheter every day.<br><br>On 06/05/24 at 8:33 AM, an observation was made of Resident #72 lying in bed with urinary catheter drainage bag on the floor.<br><br>A side by side observation and interview was conducted on 06/05/25 at 8:38 AM with Staff H, CNA, who acknowledged the catheter drainage bag for Resident #72 was on the floor and she said she would hang it.<br><br>An interview was conducted on 06/05/25 at 9:00 AM with Staff A, LPN, who was asked if urinary catheter drainage bags can be placed on the floor. She stated, no, they should be hanging from the side of the bed and below the resident's bladder at all times. |